FOR OHF USE

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2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0032797

Facility Name: SHARON HEALTH CARE, WILLOWS, INC.

Address: 3520 N. ROCHELLE (Number) PEORIA (City) 61604 (Zip Code)

County: PEORIA

Telephone Number: (309) 685-0451 **Fax #** (309) 688-4495

IDPA ID Number: 36-3530584001

Date of Initial License for Current Owners: 8/15/97

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Steve N. Lavenda **Telephone Number:** (847) 236-1111

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/00 to 12/31/00 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment

Officer or Administrator of Provider

(Signed) _____ (Date)

(Type or Print Name) _____

(Title) _____

Paid Preparer

(Signed) SEE ACCOUNTANT'S REPORT ATTACHED (Date)

(Print Name and Title) RICHARD SGARLATA, C.P.A.

(Firm Name & Address) FROST, RUTTENBERG & ROTHBLATT, P.C.
111 Pfingsten Rd. , Suite 300, Deerfield, Il 60015

(Telephone) (847) 236-1111 Fax # (847) 236-1155

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number SHARON HEALTH CARE, WILLOWS, INC. # 0032797 Report Period Beginning: 01/01/00 Ending: 12/31/00

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	219	Intermediate (ICF)	219	80,154	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	219	TOTALS	219	80,154	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF	74,545	2,621		77,166	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	74,545	2,621		77,166	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 96.27%

D. How many bed-hold days during this year were paid by Public Aid?
1,209 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
N/A

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 8/15/97

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 8/15/97 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [ ] NO [X] If YES, enter number of beds certified _____ and days of care provided _____

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/00 Fiscal Year: 12/31/00

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number SHARON HEALTH CARE, WILLOWS, IN(# 0032797 Report Period Beginning: 01/01/00 Ending: 12/31/00

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage	Supplies	Other	Total	Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	316,413	43,763	14,067	374,243		374,243		374,243			1
2	Food Purchase		334,243		334,243		334,243	(113)	334,130			2
3	Housekeeping	278,020	71,344		349,364		349,364		349,364			3
4	Laundry	107,517	45,397		152,914		152,914		152,914			4
5	Heat and Other Utilities			175,634	175,634		175,634	1,365	176,999			5
6	Maintenance	158,503		107,982	266,485		266,485	4,387	270,872			6
7	Other (specify):*											7
8	**TOTAL General Services**	860,453	494,747	297,683	1,652,883		1,652,883	5,639	1,658,522			8
	B. Health Care and Programs											
9	Medical Director			20,200	20,200		20,200		20,200			9
10	Nursing and Medical Records	1,408,519	52,461	221,165	1,682,145		1,682,145		1,682,145			10
10a	Therapy	147,554		11,363	158,917		158,917		158,917			10a
11	Activities	149,418	22,296	4,524	176,238		176,238		176,238			11
12	Social Services	173,373		17,549	190,922		190,922		190,922			12
13	Nurse Aide Training	1,644	2,799	1,320	5,763		5,763		5,763			13
14	Program Transportation			7,408	7,408		7,408		7,408			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,880,508	77,556	283,529	2,241,593		2,241,593		2,241,593			16
	C. General Administration											
17	Administrative	280,917		269,096	550,013		550,013	(132,086)	417,927			17
18	Directors Fees											18
19	Professional Services			33,426	33,426		33,426	(10,719)	22,707			19
20	Dues, Fees, Subscriptions & Promotions			23,531	23,531		23,531	(3,541)	19,990			20
21	Clerical & General Office Expenses	140,355	38,011	27,726	206,092		206,092	(9,753)	196,339			21
22	Employee Benefits & Payroll Taxes			428,603	428,603		428,603	(5,560)	423,043			22
23	Inservice Training & Education											23
24	Travel and Seminar			3,956	3,956		3,956	28	3,984			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			70,457	70,457		70,457	86	70,543			26
27	Other (specify):*							6,951	6,951			27
28	**TOTAL General Administration**	421,272	38,011	856,795	1,316,078		1,316,078	(154,594)	1,161,484			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	3,162,233	610,314	1,438,007	5,210,554		5,210,554	(148,955)	5,061,599			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

SHARON HEALTH CARE, WILLOWS, INC.
0032797
COST REPORT RECLASSIFICATIONS
01/01/00
12/31/00

SCHEDULE V LINE #		
22	EMPLOYEE BENEFITS	
2	FOOD	

To reclass cost of employee meals from raw food to employee benefits

33	REAL ESTATE TAX	
19	PROFESSIONAL FEES	

To reclass cost of appealing real estate taxes

Facility Name & ID Number SHARON HEALTH CARE, WILLOWS, INC. #0032797 Report Period Beginning: 01/01/00 Ending: 12/31/00

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			42,746	42,746		42,746	172,556	215,302			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							166,262	166,262			32
33	Real Estate Taxes			76,358	76,358		76,358	6,768	83,126			33
34	Rent-Facility & Grounds			839,040	839,040		839,040	(826,847)	12,193			34
35	Rent-Equipment & Vehicles			22,490	22,490		22,490		22,490			35
36	Other (specify):*							(41,287)	(41,287)			36
37	**TOTAL Ownership**			980,634	980,634		980,634	(522,548)	458,086			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			120,232	120,232		120,232		120,232			42
43	Other (specify):*							(32,350)	(32,350)			43
44	**TOTAL Special Cost Centers**			120,232	120,232		120,232	(32,350)	87,882			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,162,233	610,314	2,538,873	6,311,420		6,311,420	(703,853)	5,607,567			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number SHARON HEALTH CARE, WILLOWS, INC. # 0032797 Report Period Beginning: 01/01/00 Ending: 12/31/00

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	38,819	30		9
10	Interest and Other Investment Income	(33,731)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(113)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment	(4,918)	22		19
20	Contributions	(3,011)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(207)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(3,104)	21		26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(48,018)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (54,283)		$	30

OHF USE ONLY									
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(649,570)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (649,570)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (703,853)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

SHARON HEALTH CARE, WILLOWS, INC.

ID# 0032797

Report Period Beginning: 01/01/00

Ending: 12/31/00

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Deferred Maintenance	$ 3,692	6	1
2	MISCELLANEOUS INCOME	(80)	21	2
3	RISK MANAGEMENT FEES	(12,000)	19	3
4	PENALTIES	(5,460)	21	4
5	COPE DUES - ICLTC	(329)	20	5
6	RESIDENT GIFTS	(642)	22	6
7	NON-ALLOWABLE SALARY	(32,350)	43	7
8	PAINTING AND DECORATING	(877)	6	8
9	2000 SEMINAR EXPENSE ADJ OUT IN 1999	28	24	9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
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32				32
33				33
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35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49				49
50				50
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74				74
75				75
76				76
77				77
78				78
79				79
80				80
81				81
82				82
83				83
84				84
85				85
86				86
87				87
88				88
89				89
90	**Total**	(48,018)		90

STATE OF ILLINOIS

Summary A

Facility Name & ID Number SHARON HEALTH CARE, WILLOWS, INC. # 0032797 Report Period Beginning: 01/01/00 Ending: 12/31/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary													1
2	Food Purchase	(113)											(113)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities						1,365						1,365	5
6	Maintenance	2,815					1,572						4,387	6
7	Other (specify):*													7
8	**TOTAL General Services**	2,702					2,937						5,639	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records													10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	Nurse Aide Training													13
14	Program Transportation													14
15	Other (specify):*													15
16	**TOTAL Health Care and Programs**													16
	C. General Administration													
17	Administrative				(132,086)								(132,086)	17
18	Directors Fees													18
19	Professional Services	(12,000)		408	251	622							(10,719)	19
20	Fees, Subscriptions & Promotions	(3,547)					6						(3,541)	20
21	Clerical & General Office Expenses	(8,644)					(1,109)						(9,753)	21
22	Employee Benefits & Payroll Taxes	(5,560)											(5,560)	22
23	Inservice Training & Education													23
24	Travel and Seminar	28											28	24
25	Other Admin. Staff Transportation													25
26	Insurance-Prop.Liab.Malpractice						86						86	26
27	Other (specify):*				4,984		1,967						6,951	27
28	**TOTAL General Administration**	(29,723)		408	(126,851)	622	950						(154,594)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(27,021)		408	(126,851)	622	3,887						(148,955)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number SHARON HEALTH CARE, WILLOWS, INC. # 0032797 **Report Period Beginning:** 01/01/00 **Ending:** 12/31/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense D. Ownership	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
30	Depreciation	38,819		132,352		1,385							172,556	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(33,731)		199,985		8							166,262	32
33	Real Estate Taxes			(1,229)		3,788	4,209						6,768	33
34	Rent-Facility & Grounds			(806,540)		(4,000)	(16,307)						(826,847)	34
35	Rent-Equipment & Vehicles													35
36	Other (specify):*					(41,287)							(41,287)	36
37	**TOTAL Ownership**	5,088		(475,432)		(40,106)	(12,098)						(522,548)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(32,350)											(32,350)	43
44	**TOTAL Special Cost Centers**	(32,350)											(32,350)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(54,283)		(475,024)	(126,851)	(39,484)	(8,211)						(703,853)	45

Facility Name & ID Number SHARON HEALTH CARE, WILLOWS, INC. # 0032797 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
SEE ATTACHED		SEE ATTACHED		SEE ATTACHED		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [ ] YES [X] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V			$			$	$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$	$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number SHARON HEALTH CARE, WILLOWS, INC. # 0032797 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	19	PROFESSIONAL FEES	$	PEORIA FOREST PARTNERSHIP	100.00%	$ 408	$ 408	15
16	V	30	DEPRECIATION		PEORIA FOREST PARTNERSHIP		132,352	132,352	16
17	V	32	INTEREST		PEORIA FOREST PARTNERSHIP		199,985	199,985	17
18	V	33	REAL ESTATE TAX		PEORIA FOREST PARTNERSHIP		(1,229)	(1,229)	18
19	V								19
20	V	34	RENT	806,540	PEORIA FOREST PARTNERSHIP			(806,540)	20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 806,540			$ 331,516	$ * (475,024)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number SHARON HEALTH CARE, WILLOWS, INC. # 0032797 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	19	PROFESSIONAL FEES	$	REDWOOD MANAGEMENT	100.00%	$ 251	$ 251	15
16	V								16
17	V	17	MANAGEMENT FEES	269,096	REDWOOD MANAGEMENT			(269,096)	17
18	V								18
19	V	17	SALARY-L.SHLOFROCK		REDWOOD MANAGEMENT		101,760	101,760	19
20	V	27	PAYROLL TAXES-LS		REDWOOD MANAGEMENT		2,273	2,273	20
21	V								21
22	V	17	SALARY-J.SHLOFROCK		REDWOOD MANAGEMENT		15,000	15,000	22
23	V	27	PAYROLL TAXES-JS		REDWOOD MANAGEMENT		1,154	1,154	23
24	V								24
25	V	17	SALARY-S. ARON		REDWOOD MANAGEMENT		15,000	15,000	25
26	V	27	PAYROLL TAXES-SA		REDWOOD MANAGEMENT		1,154	1,154	26
27	V								27
28	V	17	SALARY-J.MAGIT		REDWOOD MANAGEMENT		5,250	5,250	28
29	V	27	PAYROLL TAXES-JM		REDWOOD MANAGEMENT		404	404	29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 269,096			$ 142,245	$ * (126,851)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number SHARON HEALTH CARE, WILLOWS, INC. # 0032797 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	19	PROFESSIONAL FEES	$	UNIT SIX PARTNERSHIP	100.00%	$ 622	$ 622	15
16	V	30	DEPRECIATION		UNIT SIX PARTNERSHIP		1,385	1,385	16
17	V	32	INTEREST		UNIT SIX PARTNERSHIP		8	8	17
18	V	33	REAL ESTATE TAX		UNIT SIX PARTNERSHIP		3,788	3,788	18
19	V	36	GAIN ON SALE OF ASSET		UNIT SIX PARTNERSHIP		(41,287)	(41,287)	19
20	V								20
21	V	34	RENT	4,000	UNIT SIX PARTNERSHIP			(4,000)	21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 4,000			$ (35,484)	$ * (39,484)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number SHARON HEALTH CARE, WILLOWS, INC. # 0032797 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	UTILITIES	$	BARTON MANAGEMENT INC.	100.00%	$ 1,365	$ 1,365	15
16	V	6	REPAIRS AND MAINT.		BARTON MANAGEMENT INC.		1,572	1,572	16
17	V	20	DUES, SUBS. & FEES		BARTON MANAGEMENT INC.		6	6	17
18	V	21	CLERICAL AND GENERAL		BARTON MANAGEMENT INC.		(1,109)	(1,109)	18
19	V	26	INSURANCE		BARTON MANAGEMENT INC.		86	86	19
20	V	27	EMP. BEN. GEN. ADMIN		BARTON MANAGEMENT INC.		1,967	1,967	20
21	V	33	REAL ESTATE TAXES		BARTON MANAGEMENT INC.		4,209	4,209	21
22	V	34	RENT OFFICE SPACE		BARTON MANAGEMENT INC.		12,193	12,193	22
23	V								23
24	V								24
25	V								25
26	V								26
27	V	34	RENT	28,500	BARTON MANAGEMENT INC.			(28,500)	27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 28,500			$ 20,289	$ * (8,211)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number SHARON HEALTH CARE, WILLOWS, INC. # 0032797 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number SHARON HEALTH CARE, WILLOWS, INC. # 0032797 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number SHARON HEALTH CARE, WILLOWS, INC. # 0032797 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number SHARON HEALTH CARE, WILLOWS, INC. # 0032797 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number SHARON HEALTH CARE, WILLOWS, INC. # 0032797 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number SHARON HEALTH CARE, WILLOWS, IN # 0032797 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	LEON SHLOFROCK	SHAREHOLDER	Administrative	21.12%	SEE ATTACHED	4	8.00	Alloc-RDWD	$ 101,760	17-7	1
2	JOHN SHLOFROCK	SHAREHOLDER	Administrative	9.57%	SEE ATTACHED	8	17.00	Alloc-RDWD	15,000	17-7	2
3	JOHN SHLOFROCK	SHAREHOLDER	Administrative	9.57%	SEE ATTACHED	8	17.00	SALARY	17,463	17-1	3
4	JOE MAGIT	SHAREHOLDER	Administrative	8.55%	SEE ATTACHED	3	9.00	Alloc-RDWD	5,250	17-7	4
5	STAN ARON	SHAREHOLDER	Administrative	11.65%	SEE ATTACHED	3.5	5.00	Alloc-RDWD	15,000	17-7	5
6	ELISA-SHLOFROCK-ZUSM	SHAREHOLDER	Clerical	2.05%	SEE ATTACHED	5.5	13.75	SALARY	11,738	21-1	6
7	JEAN SHLOFROCK	RELATIVE	Clerical	0.00	SEE ATTACHED	7	17.50	SALARY	3,149	21-1	7
8	GARY WEINTRAUB	SHAREHOLDER	Legal	2.05%	SEE ATTACHED	5	12.50	Alloc-RDWD	39,170	17-1	8
9											9
10											10
11											11
12											12
13								TOTAL	$ 208,530		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees) FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.

Facility Name & ID Number SHARON HEALTH CARE, WILLOWS, INC. # 0032797 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number (
Fax Number (

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1										1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number SHARON HEALTH CARE, WILLOWS, INC. # 0032797 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: PEORIA FOREST PARTNERSHIP
Street Address: 465 CENTRAL AVE. ,SUITE 100
City / State / Zip Code: NORTHFIELD, IL. 60093
Phone Number: ((847) 441-8200
Fax Number: ((847) 441-0800

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	19	PROFESSIONAL FEES	BED SIZE	590	4	$ 1,100	$	219	$ 408	1
2	30	DEPRECIATION	BED SIZE	590	4	356,566		219	132,352	2
3	32	INTEREST	BED SIZE	590	4	538,773		219	199,985	3
4	33	REAL ESTATE TAX	BED SIZE	590	4	(3,311)		219	(1,229)	4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 893,128	$		$ 331,516	25

Facility Name & ID Number SHARON HEALTH CARE, WILLOWS, INC. # 0032797 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: REDWOOD MANAGEMENT
Street Address: 465 CENTRAL AVE. ,SUITE 100
City / State / Zip Code: NORTHFIELD, IL. 60093
Phone Number: ((847) 441-8200
Fax Number: ((847) 441-0800

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	19	PROFESSIONAL FEES	BED SIZE	590	4	$ 675	$	219	$ 251	1
2										2
3										3
4										4
5	17	SALARY-L.SHLOFROCK	AVG HOURS WORKED	25	5	636,000	636,000	4	101,760	5
6	27	PAYROLL TAXES-LS	AVG HOURS WORKED	25	5	14,206		4	2,273	6
7										7
8	17	SALARY-J.SHLOFROCK	AVG HOURS WORKED	32	4	60,000	60,000	8	15,000	8
9	27	PAYROLL TAXES-JS	AVG HOURS WORKED	32	4	4,615		8	1,154	9
10										10
11	17	SALARY-S. ARON	AVG HOURS WORKED	14	4	60,000	60,000	4	15,000	11
12	27	PAYROLL TAXES-SA	AVG HOURS WORKED	14	4	4,615		4	1,154	12
13										13
14	17	SALARY-J.MAGIT	AVG HOURS WORKED	12	4	21,000	21,000	3	5,250	14
15	27	PAYROLL TAXES-JM	AVG HOURS WORKED	12	4	1,616		3	404	15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 802,727	$ 777,000		$ 142,245	25

Facility Name & ID Number SHARON HEALTH CARE, WILLOWS, INC. # 0032797 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: UNIT SIX PARTNERSHIP
Street Address: 465 CENTRAL AVE. ,SUITE 100
City / State / Zip Code: NORTHFIELD, IL. 60093
Phone Number: ((847) 441-8200
Fax Number: ((847) 441-0800

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	19	PROFESSIONAL FEES	BED SIZE	590	4	$ 1,675	$	219	$ 622	1
2	30	DEPRECIATION	BED SIZE	590	4	3,731		219	1,385	2
3	32	INTEREST	BED SIZE	590	4	22		219	8	3
4	33	REAL ESTATE TAX	BED SIZE	590	4	10,206		219	3,788	4
5	36	GAIN ON SALE OF ASSET	BED SIZE	590	4	(111,229)		219	(41,287)	5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ (35,484)	25

Facility Name & ID Number SHARON HEALTH CARE, WILLOWS, INC. # 0032797 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: BARTON MANAGEMENT INC.
Street Address: 465 CENTRAL AVE.
City / State / Zip Code: NORTHFIELD, IL 60093
Phone Number: (847) 441-8200
Fax Number: (847) 441-0800

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	RENTAL INCOME	199,800	8	$ 9,569	$	28,500	$ 1,365	1
2	6	REPAIRS AND MAINT.	RENTAL INCOME	199,800	8	11,020		28,500	1,572	2
3	20	DUES, SUBS. & FEES	RENTAL INCOME	199,800	8	40		28,500	6	3
4	21	CLERICAL AND GENERAL	RENTAL INCOME	199,800	8	(7,772)		28,500	(1,109)	4
5	26	INSURANCE	RENTAL INCOME	199,800	8	604		28,500	86	5
6	27	EMP. BEN. GEN. ADMIN	RENTAL INCOME	199,800	8	13,792		28,500	1,967	6
7	33	REAL ESTATE TAXES	RENTAL INCOME	199,800	8	29,507		28,500	4,209	7
8	34	RENT OFFICE SPACE	RENTAL INCOME	199,800	8	85,477		28,500	12,193	8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 142,237	$		$ 20,289	25

Facility Name & ID Number SHARON HEALTH CARE, WILLOWS, INC. # 0032797 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number SHARON HEALTH CARE, WILLOWS, INC. # 0032797 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number SHARON HEALTH CARE, WILLOWS, INC. # 0032797 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number SHARON HEALTH CARE, WILLOWS, INC. # 0032797 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number SHARON HEALTH CARE, WILLOWS, INC. # 0032797 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number SHARON HEALTH CARE, WILLOWS, IN(# 0032797 Report Period Beginning: 01/01/00 Ending: 12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$	$			$	9
	B. Non-Facility Related*											
10	Supplemental Schedule										166,262	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ 166,262	14
15	TOTALS (line 9+line14)						$	$			$ 166,262	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number SHARON HEALTH CARE, WILLOWS, INC. # 0032797 Report Period Beginning: 01/01/00 Ending: 12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
1	ALLOC-PEORIA FOREST	X									199,985	1
2	ALLOC-UNIT SIX	X									8	2
3	INTEREST INCOME										(33,731)	3
4												4
5												5
6												6
7												7
8												8
9												9
10												10
11												11
12												12
13												13
14												14
15												15
16												16
17												17
18												18
19												19
20												20
21							$	$			$ 166,262	21

Facility Name & ID Number SHARON HEALTH CARE, WILLOWS, INC. # 0032797 Report Period Beginning: 01/01/00 Ending: 12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 1999 report.	$	73,860	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	80,766	2
3. Under or (over) accrual (line 2 minus line 1).	$	6,906	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	$	76,218	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	$		5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND $ For 19 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6	$	83,124	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1995	63,984	8
	1996	61,799	9
	1997	64,480	10
	1998	71,709	11
	1999	73,998	12

CALCULATION OF 2000 ACCRUAL = 73998 X 1.03 = 76218

ALLOC-BARTON MANAGEMENT = 4209

ALLOC-UNIT SIX PARTNERSHIP = 3788

ALLOC-PEORIA FOREST = (1229)

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 1999	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity. This denial must be no more than four years old at the time the cost report is filed.

Facility Name & ID Number SHARON HEALTH CARE, WILLOWS, INC. # 0032797 Report Period Beginning: 01/01/00 Ending: 12/31/00

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: _____ B. General Construction Type: Exterior _____ Frame _____ Number of Stories 1

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

SHARON HEALTHCARE PINES - FACILITY - 120 BEDS
SHARON HEALTHCARE WOODS - FACILITY - 152 BEDS
SHARON HEALTHCARE ELMS - FACILITY - 99 BEDS
PEORIA FOREST PARTNERSHIP - DIETARY BUILDING

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: N/A
2. Number of Years Over Which it is Being Amortized: _____
3. Current Period Amortization: _____
4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	FACILITY			$ 232,348	1
2	ALLOC-CENTRAL DIETARY			18,559	2
3	TOTALS			$ 250,907	3

Facility Name & ID Number SHARON HEALTH CARE, WILLOWS, INC. # 0032797 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	219		1991		$ 4,127,141	$ 131,037	35	$ 131,037	$	$ 1,272,151	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1988	12,982	660	20	767	107	8,872	9
10	Various			1990	15,966	614	20	849	235	7,796	10
11	Various			1991	1,595	51	20	80	29	663	11
12	Various			1992	13,429	464	20	691	227	5,237	12
13	Various			1993	5,656	154	20	283	129	1,954	13
14	Various			1994	3,579	92	20	179	87	1,086	14
15	Various			1995	29,692	761	20	1,484	723	8,267	15
16	FLOORING			1996	3,126	80	20	156	76	702	16
17	LIGHT FIXTURES			1996	1,569	40	20	78	38	377	17
18	FLOORING			1996	1,772	45	20	89	44	378	18
19	WATER HEATER			1996	1,917	49	20	96	47	448	19
20	FLOORING			1996	3,374	87	20	169	82	803	20
21	DOOR			1996	1,355	35	20	68	33	289	21
22	DETECTORS			1997	624	16	20	31	15	98	22
23	DOOR SYSTEM			1997	2,120	54	20	106	52	389	23
24											24
25	PAGE 12-1 REP TOTALS				180,177	5,732		4,347	(1,385)	30,529	25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34	PAGE 12B TOTALS				54,783	870		1,771	901	2,080	34
35	PAGE 12A TOTALS				235,971	6,423		11,799	5,376	41,772	35
36	TOTAL (lines 4 thru 35)				$ 4,696,828	$ 147,264		$ 154,080	$ 6,816	$ 1,383,891	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number SHARON HEALTH CARE, WILLOWS, INC. # 0032797 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	COMPRESSOR			1997	1,214	31	20	61	30	208	9
10	FIRE SUPRESS SYS			1997	1,579	40	20	79	39	309	10
11	DRIVEWAY EXCAVATION			1997	12,549	322	20	627	305	2,299	11
12	WATER HEATER			1997	1,867	48	20	93	45	341	12
13	ELEC.LINES			1997	740	19	20	37	18	136	13
14	FIRE ALARM			1997	595	15	20	30	15	110	14
15	BRIDGE N/S BLDG			1997	152,486	3,910	20	7,624	3,714	29,861	15
16	FIRE ALARM-RAMP			1997	626	16	20	31	15	111	16
17	ELEC.PANEL			1997	1,084	28	20	54	26	185	17
18	ROOF REPAIR			1997	4,974	128	20	249	121	809	18
19	SOFTENER TANK			1997	1,484	38	20	74	36	228	19
20	DRAPERY			1997	6,739	173	20	337	164	1,208	20
21	ELEC.WIRING			1997	839	22	20	42	20	140	21
22	FIRE STA COVER			1998	1,165	30	20	58	28	145	22
23	4 NEW OFFICES			1998	21,517	552	20	1,076	524	2,780	23
24	PAVE LOT			1998	1,500	128	20	75	(53)	175	24
25	AMER II MINUTEMAN			1998	602	15	20	30	15	73	25
26	A/C COMPRESSORS			1998	3,172	81	20	159	78	384	26
27	COOLER CONDENSOR			1998	1,331	34	20	67	33	151	27
28	PHONE SHELF			1998	458	12	20	23	11	59	28
29	LANDSCAPING			1998	4,700	402	20	235	(167)	529	29
30	ROOFTOP UNIT			1998	6,245	160	20	312	152	650	30
31	ROOFING			1998	4,351	112	20	218	106	491	31
32	LAWN COMPRESSOR			1998	572	15	20	29	14	73	32
33	WINDOWS			1999	179	5	20	9	4	17	33
34	DOORS			1999	741	19	20	37	18	56	34
35	FREEZER CONDENSOR			1999	2,662	68	20	133	65	244	35
36	TOTAL (lines 4 thru 35)				$ 235,971	$ 6,423		$ 11,799	$ 5,376	$ 41,772	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number SHARON HEALTH CARE, WILLOWS, INC. # 0032797 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	GARAGE DOOR			1999	315	8	20	16	8	29	9
10	A/C COMPRESSOR			1999	869	22	20	43	21	68	10
11	ROOF			1999	3,868	99	20	193	94	290	11
12	CUBICAL CURTAINS			1999	1,164	30	20	58	28	73	12
13	WINDOWS (3)			1999	722	19	20	36	17	45	13
14	ROOF			1999	6,769	174	20	338	164	394	14
15	DOORGUARD SYSTEM			1999	3,120	80	20	156	76	169	15
16	CONCRETE PARKING LOT			1999	2,144	55	20	107	52	125	16
17	LOBBY DECORATIONS			1999	987	25	20	49	24	69	17
18	WINDOWS			1999	1,020	26	20	51	25	94	18
19	PARKING SPACES			2000	3,100	16	20	39	23	39	19
20	WINDOWS (3)			2000	890	3	20	8	5	8	20
21	WATER HEATER			2000	2,274	46	20	95	49	95	21
22	TILE			2000	691	8	20	18	10	18	22
23	WINDOWS (3)			2000	722	15	20	30	15	30	23
24	A/C COMPRESSOR			2000	1,291	15	20	33	18	33	24
25	RELOCATE CABLE			2000	16,400	158	20	342	184	342	25
26	LIGHTS			2000	1,792	13	20	30	17	30	26
27	LINK-IDPH COORD			2000	2,252	17	20	38	21	38	27
28	PARKING SPACES			2000	198	1	20	3	2	3	28
29	FLOORING			2000	1,558	5	20	13	8	13	29
30	DOORS			2000	1,063	21	20	44	23	44	30
31	DOOR PART			2000	811	10	20	21	11	21	31
32	WATER HEATER			2000	763	4	20	10	6	10	32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$ 54,783	$ 870		$ 1,771	$ 901	$ 2,080	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number SHARON HEALTH CARE, WILLOWS, INC. # 0032797 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number SHARON HEALTH CARE, WILLOWS, INC. # 0032797 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number SHARON HEALTH CARE, WILLOWS, INC. # 0032797 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number SHARON HEALTH CARE, WILLOWS, INC. # 0032797 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
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22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number SHARON HEALTH CARE, WILLOWS, INC. # 0032797 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number SHARON HEALTH CARE, WILLOWS, INC. # 0032797 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number SHARON HEALTH CARE, WILLOWS, INC. # 0032797 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
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26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number SHARON HEALTH CARE, WILLOWS, INC. # 0032797 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
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26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number SHARON HEALTH CARE, WILLOWS, INC. # 0032797 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4			1991	UNIT SIX	$	$ 1,385		$	$ (1,385)	$	4
5			1991	PEORIA FOR	87,229	1,316	31.5	1,316		1,316	5
6											6
7											7
8											8
	Improvement Type**										
9	SHARON OAKS BUILDING IMPROVEMENTS		1987		3,274	104	20	104		1,365	9
10	SHARON OAKS BUILDING IMPROVEMENTS		1988		32,193	1,023	20	1,023		12,698	10
11	SHARON OAKS BUILDING IMPROVEMENTS		1989		2,460	79	20	79		918	11
12	SHARON OAKS BUILDING IMPROVEMENTS		1990		5,647	179	20	179		1,826	12
13	SHARON OAKS BUILDING IMPROVEMENTS		1991		7,588	242	20	242		2,234	13
14	SHARON OAKS BUILDING IMPROVEMENTS		1992		23,754	849	20	849		6,513	14
15	SHARON OAKS BUILDING IMPROVEMENTS		1993		7,628	217	20	217		1,638	15
16	SHARON OAKS BUILDING IMPROVEMENTS		1994		5,330	208	20	208		1,306	16
17	SHARON OAKS BUILDING IMPROVEMENTS		1995		5,074	130	20	130		715	17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$ 180,177	$ 5,732		$ 4,347	$ (1,385)	$ 30,529	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number SHARON HEALTH CARE, WILLOWS, INC. # 0032797 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
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27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number SHARON HEALTH CARE, WILLOWS, INC. # 0032797 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	$ 697,723	$ 18,591	$ 54,631	$ 36,040		$ 609,002	37
38	Current Year Purchases	38,866	5,757	1,720	(4,037)		1,720	38
39	Fully Depreciated Assets	85,916					85,916	39
40								40
41	TOTALS	$ 822,505	$ 24,348	$ 56,351	$ 32,003		$ 696,638	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42	FACILITY	1997 DODGE RAM	1999	$ 12,821	$ 4,872	$ 4,872	$	5	$ 5,513	42
43										43
44										44
45										45
46	TOTALS			$ 12,821	$ 4,872	$ 4,872	$		$ 5,513	46

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
47	Total Historical Cost	(line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	$ 5,783,061	47	
48	Current Book Depreciation	(line 36,col.5 + line 41,col.2 + line 46,col.5)	$ 176,484	48	
49	Straight Line Depreciation	(line 36,col.7 + line 41,col.3 + line 46,col.6)	$ 215,303	49	**
50	Adjustments	(line 36,col.8 + line 41,col.4 + line 46,col.7)	$ 38,819	50	
51	Accumulated Depreciation	(line 36,col.9 + line 41,col.6 + line 46,col.9)	$ 2,086,042	51	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52		$	$	$	52
53					53
54					54
55					55
56					56
57	TOTALS	$	$	$	57

G. Construction-in-Progress

	Description	Cost	
58		$	58
59			59
60			60
61		$	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

SHARON HEALTH CARE, WILLOWS, INC.
0032797
RELATED COMPANY MOVABLE EQUIPMENT SCHEDULE
12/31/00

COMPANY NAME	COST	CURRENT BOOK (FED) DEPRECIATION	STRAIGHT LINE DEPRECIATION	ADJUSTMENTS	ACCUMULATED S/L DEPRECIATION
LINE 28: PRIOR YEARS					
SHARON HEALTHCARE WILLOWS	124,894	17,761	12,494	(5,267)	50,905
PEORIA FOREST PARTNERSHIP	411,870		41,187	41,187	398,154
UNIT SIX PARTNERSHIP					
BARTON MANAGEMENT, INC.	1,203		120	120	401
ALLOCATED FROM SHARON OAKS	159,756	830	830		159,542
TOTALS	697,723	18,591	54,631	36,040	609,002
LINE 29: CURRENT YEAR					
SHARON HEALTHCARE WILLOWS	38,866	5,757	1,720	(4,037)	1,720
PEORIA FOREST PARTNERSHIP					
UNIT SIX PARTNERSHIP					
BARTON MANAGEMENT, INC.					
ALLOCATED FROM SHARON OAKS					
TOTALS	38,866	5,757	1,720	(4,037)	1,720
LINE 30: FULLY DEPRECIATED					
SHARON HEALTHCARE WILLOWS	85,916				85,916
PEORIA FOREST PARTNERSHIP					
UNIT SIX PARTNERSHIP					
BARTON MANAGEMENT, INC.					
ALLOCATED FROM SHARON OAKS					
TOTALS	85,916				85,916
TOTALS (Should Tie to Totals on Page 13)					
SHARON HEALTHCARE WILLOWS	249,676	23,518	14,214	(9,304)	138,541
PEORIA FOREST PARTNERSHIP	411,870		41,187	41,187	398,154
UNIT SIX PARTNERSHIP					
BARTON MANAGEMENT, INC.	1,203		120	120	401
ALLOCATED FROM SHARON OAKS	159,756	830	830		159,542
TOTALS	822,505	24,348	56,351	32,003	696,638

Facility Name & ID Number SHARON HEALTH CARE, WILLOWS, INC. # 0032797 Report Period Beginning: 01/01/00 Ending: 12/31/00

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: NOT APPLICABLE
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
   If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5	ALLOC-BARTON				12,193			5
6								6
7	TOTAL				$ 12,193 **			7

8. List separately any amortization of lease expense included on page 4, line 34.
   This amount was calculated by dividing the total amount to be amortized
   by the length of the lease _____.

9. Option to Buy: ☐ YES ☐ NO Terms: _____ *

10. Effective dates of current rental agreement:
    Beginning _____
    Ending _____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2001	$
13.	/2002	$
14.	/2003	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO
16. Rental Amount for movable equipment: $ 16,942 Description: SEE ATTACHED
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	FACILITY	VAN	$ 330.00	$ 5,548	17
18					18
19					19
20					20
21	TOTAL		$ 330.00	$ 5,548	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number SHARON HEALTH CARE, WILLOWS, INC. # 0032797 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [X] YES [ ] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [X]
- IN OTHER FACILITY [ ]
- COMMUNITY COLLEGE [ ]
- HOURS PER AIDE

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [X]
- IN OTHER FACILITY [ ]
- HOURS PER AIDE

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies	774	2,025		2,799
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)	455	1,189		1,644
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests	365	955		1,320
9	TOTALS	$ 1,594	$ 4,169	$	$ 5,763
10	SUM OF line 9, col. 1 and 2 (e)	$ 5,763			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$ 11,531

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	25
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	9
2. From other facilities (f)	
TOTAL TRAINED	34

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Facility Name & ID Number SHARON HEALTH CARE, WILLOWS, INC. # 0032797 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	N/A	hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): **SEE SUPPLEMENTAL SCHEDULE**									13
14	TOTAL			$		$	$		$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SUPPLEMENTAL SCHEDULE OF MEDICAL SUPPLIES

	Special Services - Supplies (Column 6 - Other)	Amount
1	Medical Supplies	
2	Complex Medical Equip	
3	Oxygen	
4	Equipment Rental	
5		
6		
7		
8		
9		
10		

	Outside Therapies (Column 5 - Other)	Amount
1	Respiratory Therapy	
2		
3		
4		
5		
6		
7		
8		
9		
10		

Facility Name & ID Number SHARON HEALTH CARE, WILLOWS, INC. # 0032797 Report Period Beginning: 01/01/00 Ending: 12/31/00

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/00 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 75,814	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,086,205		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	23,594		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See supplemental schedule	286		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,185,899	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cos	482,456		15
16	Equipment, at Historical Cost	422,256		16
17	Accumulated Depreciation (book methods)	(438,177)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See supplemental schedule			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 466,535	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,652,434	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 147,400	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	74,900		30
31	Accrued Taxes Payable (excluding real estate taxes)	14,893		31
32	Accrued Real Estate Taxes(Sch.IX-B)	76,219		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See supplemental schedule			36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 313,412	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See supplemental schedule			43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 313,412	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,339,022	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,652,434	$	48

*(See instructions.)

Facility Name & ID Number SHARON HEALTH CARE, WILLOWS, INC. **#** 0032797 **Report Period Beginning:** 01/01/00 **Ending:** 12/31/00

SUPPLEMENTAL SCHEDULE OF OTHER ASSETS & LIABILITIES **As of** 12/31/00

OTHER CURRENT ASSETS:	Amount	Amount
SECURITY DEPOSITS	286	
	286	

OTHER CURRENT LIABILITIES:	Amount	Amount
Accrued Expenses		
Accrued R. E. Tax - Non Care Property		

OTHER NON CURRENT ASSETS:		
Construction In Progress		
Utility Deposit		
Loan Costs		

OTHER NON CURRENT LIABILITIES:	Amount	Amount

Facility Name & ID Number SHARON HEALTH CARE, WILLOWS, INC. # 0032797 Report Period Beginning: 01/01/00 Ending: 12/31/00

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ 2,013,699	1	
2	Restatements (describe):		2	
3	Schedule attached		3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 2,013,699	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	200,323	7	
8	Aquisitions of Pooled Companies		8	
9	Proceeds from Sale of Stock		9	
10	Stock Options Exercised		10	
11	Contributions and Grants		11	
12	Expenditures for Specific Purposes		12	
13	Dividends Paid or Other Distributions to Owners	(875,000)	13	
14	Donated Property, Plant, and Equipment		14	
15	Other (describe)		15	
16	Other (describe)		16	
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (674,677)	17	
	B. Transfers (Itemize):			
18			18	
19			19	
20			20	
21			21	
22			22	
23	**TOTAL Transfers (sum of lines 18-22)**	$	23	
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 1,339,022	24	*

*** This must agree with page 17, line 47.**

Facility Name & ID Number	SHARON HEALTH CARE, WILLOWS	# 0032797	Report Period Beginning:	01/01/00	Ending:	12/31/00

Balance per General Ledger		2,013,699
Adjustments:		
		-
		-
		-
Total adjustments		-
Balance - Beginning of Year		2,013,699
Equity(Deficit) from Page 17 Col 1		1,339,022
Related Party		
Equity(Deficit)	0	
Income	0	
		-
Combined Equity - End of Year		1,339,022

Facility Name & ID Number SHARON HEALTH CARE, WILLOWS, INC. # 0032797 Report Period Beginning: 01/01/00 Ending: 12/31/00

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 6,462,750	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 6,462,750	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements	11,531	11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22**	$ 11,531	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	33,731	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 33,731	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See supplemental schedule	3,731	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 3,731	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 6,511,743	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,652,883	31
32	Health Care	2,241,593	32
33	General Administration	1,316,078	33
	B. Capital Expense		
34	Ownership	980,634	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	120,232	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 6,311,420	40
41	**Income before Income Taxes (line 30 minus line 40)****	200,323	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 200,323	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? Not Complete If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number SHARON HEALTH CARE, WILLO # 0032797 **Report Period Beginning:** 01/01/00 **Ending:** 12/31/00

SUPPLEMENTAL SCHEDULE OF REVENUES
12/31/00

	DESCRIPTION	AMOUNT
1	MISC. INCOME - ADJUSTED OFF PAGE 5	80
2	VENDING COMMISSIONS	3,136
3	PHONE COMMISSIONS	515
4		
5		
6		
7		
8		
9		
10		
11		
12		
13		
14		
15		
16		
17		
18		
19		
20		
	TOTALS	3,731

Facility Name & ID Number SHARON HEALTH CARE, WILLOWS, INC. # 0032797 Report Period Beginning: 01/01/00 Ending: 12/31/00

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,080	2,227	$ 49,176	$ 22.08	1
2	Assistant Director of Nursing	2,565	3,132	56,829	18.14	2
3	Registered Nurses	31,376	33,952	621,281	18.30	3
4	Licensed Practical Nurses					4
5	Nurse Aides & Orderlies	68,975	74,111	644,259	8.69	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	12,877	14,377	147,554	10.26	8
9	Activity Director					9
10	Activity Assistants	16,831	18,255	149,418	8.19	10
11	Social Service Workers	14,228	15,041	173,373	11.53	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	33,780	36,078	316,413	8.77	15
16	Dishwashers					16
17	Maintenance Workers	17,808	18,919	158,503	8.38	17
18	Housekeepers	39,200	40,620	278,020	6.84	18
19	Laundry	13,683	14,909	107,517	7.21	19
20	Administrator	2,080	2,080	82,061	39.45	20
21	Assistant Administrator	880	909	58,639	64.51	21
22	Other Administrative	1,831	1,970	140,217	71.18	22
23	Office Manager					23
24	Clerical	9,427	10,188	140,355	13.78	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	3,758	4,246	36,974	8.71	31
32	Other Health Care(specify)					32
33	Other(specify)	110	119	1,644	13.82	33
34	TOTAL (lines 1 - 33)	271,489	291,133	$ 3,162,233 *	$ 10.86	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	380	$ 14,067	1-3	35
36	Medical Director	135	20,200	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	96	1,920	10-3	39
40	Physical Therapy Consultant	160	7,200	10A-3	40
41	Occupational Therapy Consultant	80	3,581	10A-3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	13	582	10A-3	43
44	Activity Consultant	129	4,523	11-3	44
45	Social Service Consultant	140	4,899	12-3	45
46	Other(specify) PSYCHIATRIC	195	12,650	12-3	46
47	DENTAL CONSULTANT	41	1,836	10-3	47
48					48
49	TOTAL (lines 35 - 48)	1,369	$ 71,458		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	988	$ 32,611	10-3	50
51	Licensed Practical Nurses	776	21,741	10-3	51
52	Nurse Aides	10,320	163,057	10-3	52
53	TOTAL (lines 50 - 52)	12,084	$ 217,409		53

Facility Name & ID Number SHARON HEALTH CARE, WILLOWS, INC. # 0032797 Report Period Beginning: 01/01/00 Ending: 12/31/00

SUPPLEMENTAL SCHEDULE OF STAFFING AND SALARY COSTS

B. CONSULTANT SERVICES

	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage
CNA TRAINER	110	119	$ 1,644	$ 13.82
	110	119	$ 1,644	$ 13.82

Facility Name & ID Number SHARON HEALTH CARE, WILLOWS, INC. # 0032797 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
SEE ATTACHED			$ 280,917
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 280,917

B. Administrative - Other

Description	Amount
MANAGEMENT FEES-REDWOOD MANAGEMENT	$ 269,096
TOTAL (agree to Schedule V, line 17, col. 3)	$ 269,096
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
PENSION PERFORMANCE	PENSION PLAN	$ 632
FR&R	ACCOUNTING	7,424
ALPHA DATA SERVICES	DATA PROCESSING	5,197
CENTRAL PLAZA-THRESHOLD	COMPUTER	2,644
COMPUTER AGE	COMPUTER	315
MEDE AMERICA	COMPUTER	172
MID AMERICA PROGRAM	COMPUTER	1,320
ALLOC-BARTON	COMPUTER	804
PERSONNEL PLANNERS	UNEMPLOYEMENT CONS.	2,919
	* RISK MGMT FEES	12,000
* ADJUSTED OUT PAGE 5		
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 33,427

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 90,771
Unemployment Compensation Insurance	35,711
FICA Taxes	230,255
Employee Health Insurance	50,891
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
EMPLOYEE BENEFITS	7,575
CHRISTMAS EXPENSE	6,265
EMPLOYEE RETIREMENT PLAN CONTRIB	1,575
TOTAL (agree to Schedule V, line 22, col.8)	$ 423,043

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	10,169
Health Care Worker Background Check	1,311
(Indicate # of checks performed 187)	
DUES, SUBSCRIPTIONS	614
DUES-ICLTC	6,679
ALLOC-BARTON	164
LICENSES, FEES, PERMITS	1,053
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 19,990

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	3,984
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 3,984

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number SHARON HEALTH CARE, WILLOWS, INC. # 0032797 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1997	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005
1	PAINTING AND DECO	1994	$ 1,988	3	$ 331	$	$	$	$	$	$	$	$
2	PAINTING AND DECO	1995	29,856	3	9,954	4,976							
3	PAINTING AND DECO	1998	9,630	3		1,605	3,210	3,210	1,605				
4	PAINTING AND DECO	1999	1,009	3			168	336	336	168			
5	PAINTING AND DECO	2000	877	3				146	292	292	147		
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$ 43,360		$ 10,285	$ 6,581	$ 3,378	$ 3,692	$ 2,233	$ 460	$ 147	$	$

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **YES**

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **ICLTC-6679**

(3) Did the nursing home make political contributions or payments to a politica action organization? **YES** If YES, have these costs been properly adjusted out of the cost report? **YES**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **10 YEARS**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **NONE** Line

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions fo Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Departmen of Public Aid during this cost report period. $ **120,231**
This amount is to be recorded on line 42 of Schedule V

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classifiec in the Ancillary Section of Schedule V? **NO**

(14) Is a portion of the building used for any function other than long term care services fo the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions

(15) Indicate the cost of employee meals that has been reclassified to employee benefit on Schedule V. $ Has any meal income been offset against related costs? **N/A** Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation fo residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **100% of In**
d. Have vehicle usage logs been maintained? **NO**
e. Are all vehicles stored at the nursing home during the night and all othe times when not in use? **YES**
f. Has the cost for commuting or other personal use of autos been adjustec out of the cost report? **YES**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted ou out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of service performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.

Date: **07/17/2000**

To: **Administrator/Cost Report Preparer**

From: **Office of Health Finance**

Re: 2000 Long Term Care Cost Report and Instructions on Diskette
Information Regarding the Lotus 5.0 and Excel 97 Versions of the Cost Report

Enclosed you will find a copy of the 2000 cost report and instructions on diskette. For 1999, the majority of nursing homes used the diskette to prepare their cost report. We would appreciate it if you could complete your 2000 cost report using this diskette.

If you choose not to use the diskette, you may print the 2000 cost report form and manually complete the report. If you do not have the ability to print the cost report form and instructions, please contact our office at 217/782-1630 to request a paper copy to be mailed to you.

As is stated on page 1 of the cost report instructions, this report should cover the facility's fiscal year ending in 2000. It is due on September 30, 2000, or ninety days after the close of the facility's fiscal year, **whichever comes later**. Please refer to the instructions for the remainder of the filing requirements.

There are two 2000 cost report files on the disk you have received. One file has been created for use with Lotus 5.0 for Windows. The other file has been created for use with Excel 97. A copy of the 2000 cost report instructions has been included on the diskette also. The name of the file is Instr00. It has been created for use with Word Perfect 6.1. Please use this 2000 diskette. **Printed copies of the report from the 1999 cost report diskette or earlier diskettes will NOT be accepted.**

Each page is on a separate worksheet. The file has been sealed. The cells where data is to b entered have been unprotected. Do not change the cost report form. We must have every form the same. Any changes made to the cost report form will cause us to consider the filed cost report incomplete until the form is correctly filed. Complete page one first. The facility name, IDPH ID# and the report period dates have been linked to each page. (Be sure to enter the IDPH licensed name of the facility.) **When entering data on pages 3 and 4, do not include decimals. Please round to whole numbers. When entering the years on page 12 do not enter various or other text in columns 2 or 3.**

Print macros have been written that will print each individual page or the entire report.

WARNING: Do NOT use drag & drop, cut or move commands. These commands may ruin the file and/or formulas. Then you will have to close the file and start from the last time you saved it.

As you know, save your work frequently to prevent losses of large amounts of information.

The cost report must be printed on 8 ½ by 14 size white paper with an 8 ½ by 14 image on the paper. To ensure an 8 ½ by 14 size image, check the paper size in the Printer Setup. When printing the cost report, be sure the "Selected Range" is checked. If "Current Worksheet" or "A Worksheets" are selected, the printed report will be smaller than it should be. These three selections appear in the Print dialog box. **Please do not reduce the image to 8 ½ by 11. We cannot accept a report with an 8 ½ by 11 image.** After printing the cost report, please review the copy for accuracy and completeness before mailing it to The Office of Health Finance. **Please send in the completed diskette with your paper copy, (being sure to make a copy of the diskette for your records).** Also, please make sure both the completed diskette and the paper copy agree prior to sending to our office.

Notes Applicable only to Lotus users

The entire cost report is in one file named Report00.wk4. A print preview button has been added to the bottom of each page. You may want to preview each page to ensure there are no problems before you print the entire cost report. To preview a page, click this button, then click File-Preview as normal. Also, macros have been written that will allow you to change the column width or row height of a cell or range of cells. **Only use these commands on the extra pages (24 through 33).** The print menu or the other macros menu will appear on the menu ba after you click the macro button. A macro that allows you to "Freeze Both Titles" has been added also. This will be helpful for data entry. **When saving the file in Lotus, please save it as a "WK4" file type instead of a "123" file type. To do this, click File-Save As, and then ensure the file type is "WK4".**

To copy worksheets that you have created into the blank pages at the end of the report, use Fi Combine. This will bring in the styles you used in your worksheet (except for the column width and the row height). This does not work if you are using Lotus 97. Extra sheets for pages 6, 8 and 12 have been included in the file. Click the macro buttons on these pages to make them available.

Notes Applicable only to Excel users

The entire cost report is in one file named Report00.xls. In an Excel 97 file that has been seale you can press the Tab key to go to the next unprotected cell. By pressing Shift-Tab, you can g to the previous unprotected cell. Extra sheets for pages 6, 8 and 12 have been included in the file. Click Format-Sheet-Unhide to see the sheets available. Also there are some blank unprotected sheets after "Page 23".

If you have any questions concerning the diskette, please call Randy Hulskotter at (217) 782-1630.

RH/cw